



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: HARRIS METHODIST FORT WORTH 3255 W PIONEER PKWY ARLINGTON TX 76013	MFDR Tracking #: M4-07-1421-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: FEDEX FREIGHT INC Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the APC rate of \$2194.61 for APC number #0672. Allowing this at 140% would yield a fair and reasonable allowance of \$3072.45." "In addition Medicare would have reimbursed the provider for the second OR service at half the APC rate so they would allow \$10971.31 for APC number 0672. Allowing this at 140% would yield a fair and reasonable allowance of \$1536.23." "Based on your payment of \$1111.36 a supplemental payment is still due of \$3497.32." [sic]

Amount in Dispute: \$3497.32

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that \$1,249.88 represents an amount greater than or equal to the fair and reasonable reimbursement for this service. The provider must therefore prove that the reimbursement received is not fair and reasonable."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
4/5/2006	L001, W1, W10, 850-068, 16, 855-022, M, W3, W4, 920-010, 920-002	Outpatient Surgery	\$3497.32	\$0.00
			Total Due:	\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on November 3, 2006. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on November 16, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

- For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
 - W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
 - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using

remittance advice remarks codes whenever appropriate.

- 855-022-Charge denied due to lack of sufficient documentation of services rendered \$0.00.
 - 850-068-CISGI: The recommended payment reflects a fair, reasonable and consistent methodology for reimbursement pursuant to the criteria set forth in Section 413.011(D) of the Texas Workers' Compensation Act.
 - M-No MAR.
 - L001-W1-Workers Compensation state fee schedule adjustment.
 - W3-Additional payment made on appeal/reconsideration.
 - 920-010-Upon receipt of a requested report, the recommended allowance has been adjusted.
 - W4-No additional reimbursement allowed after review of appeal/reconsideration.
 - 920-002-In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §133.307(e)(2)(C), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission." Review of the documentation submitted by the requestor finds that the requestor has indicated that the amount billed for the services in dispute is the total for all services charged on the hospital bill; however the documentation does not support that all of the services in dispute were rendered on the date of service listed on the requestor's *Table of Disputed Services*. The requestor listed the disputed date of service as 4/5/06 on the *Table*; the total charges on the bill were for date of service 4/4/06 and 4/5/06. The Division concludes that the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under Division rule at 28 TAC §133.307(e)(2)(C).
5. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
6. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
- The requestor's position statement states that "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the APC rate of \$2194.61 for APC number #0672. Allowing this at 140% would yield a fair and reasonable allowance of \$3072.45." "In addition Medicare would have reimbursed the provider for the second OR service at half the APC rate so they would allow \$10971.31 for APC number 0672. Allowing this at 140% would yield a fair and reasonable allowance of \$1536.23." "Based on your payment of \$1111.36 a supplemental payment is still due of \$3497.32." [sic]
 - The requestor does not discuss or explain how payment of 140% of Medicare rate would result in a fair and reasonable reimbursement.
 - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
 - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the

requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(2)(C), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Medical Fee Dispute Resolution Officer

9/9/2010

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.